STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155795	A. BUILDING 00 B. WING	01/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SPRINGS HEALTH CAMPUS	2400 SILHAVY ROAD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00112522, IN00114982, IN00116690, and IN00118911. Complaint IN00112522-Substantiated. Federal/state deficiency related to the allegation cited at F312. Complaint IN00114982-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F312, F314, and F441. Complaint IN00116690-Substantiated. Federal/state deficiency related to the allegation cited at F312. Complaint IN00118911-Substantiated. Federal/state deficiency related to the allegation cited at F441. Survey dates: January 6-8, 2013 Facility number: 012766 Provider number: 155795 AIM number: 201051640	F0000	The submission of this plan of correction does not indicate an admission by Avalon Springs Health Campus that the findings and allegations contained here in are accurate and true representations of the quality of care and services provided to the residents of Avalon Springs Health Campus. This facility recognized its obligation to provide legally and medically necesary care and services to its residents in an economic and efficient manner. the facility here by maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 program). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal rewuirements governing the management of this facility. It is submitted as a matter of staue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Survey team: Janet Adams, RN Census bed type: SNF: 29 SNF/NF: 12 Residential: 26 Total: 67 Census payor type: Medicare: 24 Medicaid: 9 Other: 34 Total: 67 Sample: 13 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 15, 2013, by Janelyn Kulik, RN.			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the resident's Physician related to medication orders upon admission for 2 residents in the sample of 13.	F0157	1. Resident #E was discharged from the health campus on 8/8/12. Therefore, no action could be taken to correct documentation. The physician was notified about the medication	02/07/2013

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	(Residents #E and #K) Findings include: 1. The closed record for Resident #E was reviewed on 1/7/13 at 10:30 a.m. The resident was admitted to the facility on 6/18/12. The resident was admitted from the hospital. The resident's diagnosis included, but were not limited to, arthritis, chronic obstructive pulmonary disease, macular degeneration, pelvic fracture, depression, congestive heart failure, arthritis, and osteoporosis. The 6/18/12 Physician admission orders indicated there were no orders for the resident to receive any antidepressant medications. Review of the 6/18/12 hospital Discharge Medication form indicated Lexapro (an antidepressant medication) was to be continued upon discharge. Review of the 6/12 and 7/12 Physician orders indicated there were no orders for the resident to receive Lexapro. An order was written on 8/4/12 for the resident to receive Lexapro 5 milligrams once a day for depression. When interviewed on 1/7/13 at 11:30 a.m., the Director of Nursing indicated		omission for Resident #K.2. All residents admission orders have been audited and any deficiencies found were corrected.3. All licensed staff have been in serviced on admission order procedures. All admission orders will be verified by two nurses, then audited by nurse manager.4. The Director of Health Services and/or designee will monitor the admission orders audits five days per week during Clinical Morning Meeting. The Quality Assurance Committee will receive a monthly report on how the system is working for 3 months to determine if 95% compliance on monthly report has been achieved. Then QA Committee will decide to continue monitoring or if that issue is resolved.5. February 7, 2013	

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	nursing staff were to review the hospital discharge medication sheet when a resident was admitted to the facility and to write all the medications that were listed as to be continued on a facility Physician Order Sheet. The Director of Nursing indicated the Nurses were then required to call the attending Physician to verify if each of medications were to be continued or discontinued. The Director of Nursing indicated the Lexapro was not listed on the sheet the Nurse would have used to call the attending Physician and the Lexapro was not started until 8/4/12. 2. The record for Resident #K was reviewed on 1/7/13 at 4:05 p.m. The resident was admitted to the facility on 11/30/12. The resident was admitted from the hospital. The resident's diagnoses included, but were not limited to, rib fracture, dementia, and cerebral vascular accident (stroke). The 11/30/12 admitting Physician orders indicated there were no orders for the resident to receive Augmentin(an antibiotic) or Omeprazole(a medication for gastric upset). A Physician's order was written on 1/3/13 to resume Augmentin.			

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The 11/30/12 hospital Discharge Medication form indicated Augmentin 500 milligrams three times a day and Omeprazole 40 milligrams daily were listed.

The facility policy titled "Physician Notification of Diagnostic Testing and Change in Condition" was received from the Director of Nursing on 1/7/13. The Director Nursing indicated the policy was current. The policy was dated 12/6/07. The policy indicated the resident's Physician was to be notified for changes in condition and the need for provision of appropriate interventions.

When interviewed on 1/7/13 at 4:20 p.m., the Director of Nursing indicated nursing staff were to review the hospital discharge medication sheet when the resident was admitted to the facility and to write all the medications that were listed as to be continued on a facility Physician Order Sheet. The Director of Nursing indicated the Nurses were then required to call the attending Physician to verify if each of medications were to be continued or discontinued. The Director of Nursing also indicated the Augmentin and Omeprazole were not listed on the sheet the Nurse would have used to

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	call the attending Physician. This federal tag relates to Complaint IN00114982. 3.1-5(a)(3)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure feeding assistance was provided in a timely manner for 2 of 2 residents observed in the sample of 13. (Residents #B and #C) (CNA #2) Findings include: 1. During Orientation Tour on 1/6/13 at 6:00 p.m., Resident #B was observed in bed. The resident's dinner meal tray was on the over bed table at the side of the bed. The foods were covered. There were no staff members or visitors in the room at this time. On 1/6/13 at 6:30 p.m., the resident was observed in bed. The resident's meal tray remained uncovered on the table. There were no staff members or visitors in the room at this time. On 1/6/13 at 7:05 p.m., the resident was observed in bed. The resident's	F0312	1. Immediately for residents #B and #C fresh meals and feeding assistance was provided2. During the survey process no other residents were affected by the deficiant practice.3. For any resident requiring dinning assistance according to their resident preference profile, the charge nurse will monitor to ensure feeding assistance was provided timely and then document on the resident preference profile that the certified nursing assistant provided dinning assistance in a timely manner. The resident preference profiles will be turned into nursing management to be audited.4. The Director of Health Services and/or her designee will monitor the dinning assistant audits five days per week during the Clinical Morning Meeting. The Quality assurance Committee will receive a monthly report on how the system is working for 3 months to determine if 100% compliance on monthly report has been achieved. The QA Committee will decide to continue monitoring or if that issue is resolved.5. February 7, 2013	02/07/2013

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	meal tray remained uncovered on the table at the foot of the bed. The record for Resident #B was reviewed on 1/7/13 at 11:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, osteoarthrosis, and high blood pressure. The resident was sent to the hospital on 12/28/12 and was readmitted to the facility on 1/3/13. The 1/3/13 Nursing Admission Assessment & Data Collection indicated the resident was dependent on staff for eating, grooming, bathing, and oral care. When interviewed on 1/8/13 at 8:15 a.m., the Director of Nursing indicated Resident #B should have received assistance with her meal as needed. 2. During Orientation Tour on 1/6/13 at 6:05 p.m., Resident #C was observed sitting in a recliner chair next to the bed. The resident's over bed table was at the foot of the bed. The resident's meal tray was on the table. The meal tray was covered. There were no staff members or visitors in the room. On 1/6/13 at 7:00 p.m., the resident was observed in the recliner chair next to her bed. The resident's meal			

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	tray remained covered on the over bed table at the foot of the bed. There were no staff members or visitors in the room. The record for Resident #C was reviewed on 1/7/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, behavioral disturbances, and dementia. The resident's current care plans were reviewed. A care plan initiated on 5/6/12 indicated the resident had an ADL (Activities of Daily Living) deficit or potential for as evidenced by needing assistance or being dependent on staff for eating. The care plan was last updated with a goal date of 1/18/13. When interviewed on 1/6/13 at 7:00 p.m., CNA #2 indicated she had not been in to fed the resident as of this time. When interviewed on 1/8/13 at 8:15 a.m., the Director of Nursing indicated Resident #C should have received assistance with her meal as needed. This federal tag relates to Complaints IN00112522, IN00114982, and IN00116690.			

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	3.1-38(a)(2)(D)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure treatment was provided daily as ordered by the Physician for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers in the sample of 13. (Resident #J) (LPN #1) Findings include: On 1/7/13 at 9:10 a.m., Resident #J was observed in bed. LPN #1 entered the resident's room to complete treatments to the resident's heels. The LPN removed the resident's socks from both of his feet. There were Kerlix (rolled gauze dressing used to wrap around wounds) dressings in place wrapped around both heel/ankle areas. The dressings on both of the resident's	F0314	1. The employee was immediately counseled on not completing treatment as ordered. Treatment was rendered according to order at that time and the physician was notified.2. Review of all residents was conducted and all treatments were completed as ordered.3. Nursing staff was in serviced on rendering treatments according to the physician orders including documentation on the TAR. Treatments will be audited and those audits will be documented.4. The Director of Health Services and/or her designee will monitor the treatment audits five days per week during the Clinical Morning Meeting. The Quality Assurance Committee will receive a monthly report on how the system is working for 3 months to determine 100% compliance on monthly report has been achieved. The QA Committee will decide to continue monitoring or if	02/07/2013

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	feet were dated 1/5/13 with initials written next to the dates. LPN #1 then removed the dressing from the resident's right heel. The area to the right heel was approximately 1 cm(centimeter) in diameter and had a light yellow center with pink edges. There was no drainage from the wound. After completing the treatment the LPN removed the dressing from the resident's left heel. There was a small round scab area approximately .5 cm in diameter. There was no drainage from the left heel area. The LPN then completed the treatment to the area. The record for Resident #J was reviewed on 1/8/12 at 9:00 a.m. The resident;s diagnoses included, but were not limited to, pneumonia, high blood pressure, dementia, seizures, and glaucoma. Review of the 1/2013 Treatment Administration Record indicated there was a Physician's order written on 1/2/13 to cleanse the right heel wound with wound cleanser, apply Santyl (an ointment to treat pressure ulcers) to the wound bed, cover the area with a 4 x 4 (a square gauze dressing), and then wrap with Kerlix daily and as needed. There was also a Physician's order to cleanse the left		that issue is resolved.5. February 7, 2013	

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	heel ulcer with normal saline, apply Xenaderm(an ointment to treat ulcers), and wrap with Kerlix daily and as needed. The Treatment Administration Record indicated the treatments to the right and left heels were not signed out as completed on 1/6/13. Review of the Pressure/Stasis/Arterial/Diabetic Ulcer Assessment record indicated the resident had Stage II ulcer to the left heel. An entry made on 1/2/13 indicated the ulcer measured 0.8 cm (centimeters) x 0.8 cm and was pink and moist. A second Pressure/Stasis/Arterial/Diabetic Ulcer Assessment record indicated the resident had an unstageable ulcer to the right heel. An entry made on 1/2/13 indicated the ulcer measured 1 cm x 1 cm and was pink with a black center. The resident's current care plans were reviewed. A care plan initiated on 12/24/12 last reviewed on 12/24/12 indicated the resident had alterations in skin integrity as evidenced by bilateral heel ulcers. Care plan interventions included for staff to provide treatment to the areas as ordered by the Physician.			

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	When interviewed on 1/7/13 at 9:35 a.m., after completing the heel treatments, LPN #1 indicated she worked the day shift on 1/6/13 and was assigned to care for Resident #J. The LPN indicated she did not complete dressing changes on the resident's heels on 1/6/13 as ordered by the Physician. LPN #1 indicated she had worked on 1/5/13 and completed the treatments to the resident's heels. The LPN indicated the dressings that were in place this morning were the dressings she applied on 1/5/13 as her signature was on the dressings. When interviewed on 1/8/13 at 8:15 a.m., the Director of Nursing indicated the treatments to the heel ulcers should have been completed daily as ordered. This federal tag relates to Complaint IN00114982. 3.1-40(a)(2)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to	F0441	1. Staff member was immediately counseled and	02/07/2013

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	155795	A. BUILDING 00 B. WING	01/08/2013

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	ensure infection control practices were implemented related to lack of hand washing between resident care for 1 resident in the sample of 13. (Resident #L) (CNA #1) Findings include: During Orientation Tour on 1/6/13 at 6:15 p.m., CNA #1 was observed removing a plastic bag of trash from the trash can in the Resident #L's room. The CNA was not wearing gloves. The CNA walked out of the resident's room with the full trash bag. The CNA did not wash her hands before leaving the room. The CNA walked down to the utility room to dispose of the trash. The CNA then walked back down the hall where Resident #L resided. The CNA then entered another resident's room. When interviewed at this time, CNA #1 indicated she did not wash her hands when leaving Resident #L's room or after disposing of the trash from Resident #L's room. The CNA indicated she should have washed her hands before and after emptying the trash from the room. The record for Resident #L was reviewed on 1/8/13 at 9:45 a.m. The resident's diagnoses included, but		educated on proper hand washing policy and procedure.2. During survey no other staff members were observed making deficiencies therefore no other residents were at risk.3. All staff were educated on proper hand washing according to the health campus policy and procedures with competency demonstratons to verify education. Two staff members will be randomly selected from all shifts to demonstrate proper hand washing procedures per day, five days per week. Those audits will be documented and any deficiencies will be re-educated.4. The Director of Health Services and/or designee will monitor the hand washing audits five days per week during the Clinical Morning Meeting. The Quality Assurance Committee will recieve a monthly report on how the system is working for 3 months to determine if 100% compliance on monthly report has been achieved. The QA Committee will decide to continue monitoring or if that issue is resolved.5. February 7, 2013	

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	were not limited to, high blood pressure, depression, anemia, and seizures. Review of the 12/2012 Physician orders indicated an order was obtained on 12/28/12 to collect a stool specimen for C-Diff (a stool infection). There was also an order for the resident to receive Vancomycin(an antibiotic) liquid 250 milligrams orally every 8 hours for 14 days. The 12/30/12 laboratory tests results indicated the stool specimen was collected on 12/29/12. The results indicated the specimen was positive for C-Diff. The facility policy titled "Guidelines for Management of Residents with Clostridium Difficile" was received from the Director of Nursing on 1/7/13. There was no date on the policy. The Director of Nursing indicated the policy was current. The policy indicated Contact precautions were to be initiated at the onset of diarrhea. The policy titled "Contact Precautions" was received from the Director of Nursing on 1/7/13. There was not date on the policy. The Director of Nursing indicated the			

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	policy was current. The policy indicated Contact precautions included for staff to wash hands between residents. When interviewed on 1/6/13 at 6:40 p.m., the Director of Nursing indicated the CNA should have worn gloves and washed her hands after removing the trash from the residents room before entering any other room. This federal tag relates to Complaints IN00114982 and IN00118911. 3.1-18(l)			